

One Program’s Transition to Research-Based Strategies for Treating Methamphetamine Abuse

Prairie Ridge Addiction Treatment Services turned to SAMHSA’s Treatment Improvement Protocol (TIP) 33, “Treatment for Stimulant Use Disorders,” to try to establish more effective practices for their fast-growing population of methamphetamine-addicted clients. Six years later, Prairie Ridge’s executive director says that adopting the TIP’s client-based treatment philosophy has enhanced the program’s accessibility and results, not only for stimulant-abusing clients, but others as well. In this article he recounts how the TIP contents meshed with Prairie Ridge’s preexisting treatment philosophy and practices; what they adopted and what they adapted from the TIP and why; counselors’ responses during the transition; and outstanding issues.

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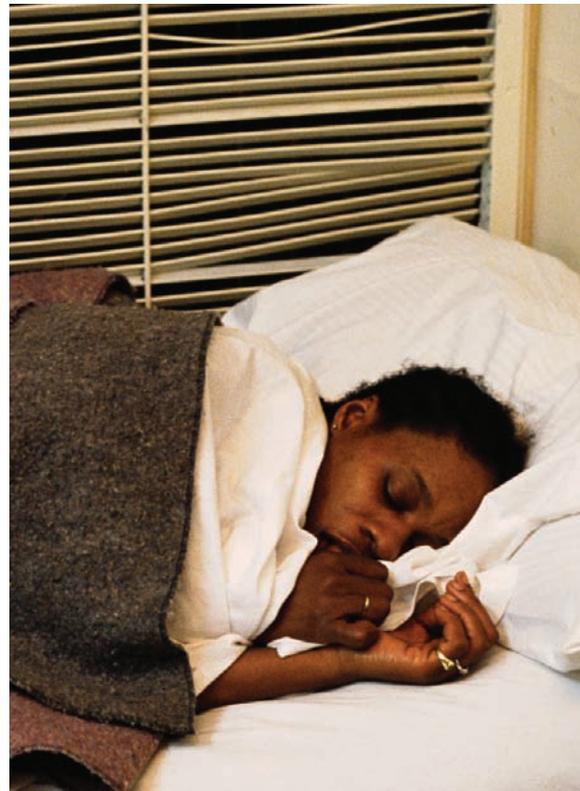
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In many ways, Prairie Ridge Addiction Treatment Services was well positioned to make good use of Treatment Improvement Protocol (TIP) 33, “Treatment for Stimulant Use Disorders,” when the Substance Abuse and Mental Health Services Administration (SAMHSA) published it in 1999. The number of clients coming to us for help with methamphetamine abuse had been rising steeply for a year, and our staff were eager for information on effective treatments. Organizationally, we were beginning to focus on implementing evidence-based practices, which is a primary rationale of the TIP. As well, we were moving toward a client-centered approach to treatment, which accords with the overall thrust of the TIP. For example, we were working to implement Dr. Carlo DiClemente’s Transtheoretical Model of Change (Prochaska and DiClemente, 1984), which focuses on engaging clients and recognizing their individual needs, while also recognizing that drug abuse treatment is a gradual process with distinct stages. We had begun accepting clients regardless of their stage of recovery, using motivational interviewing techniques, and trying to “roll with resistance” rather than pushing clients beyond their capabilities.

Our prior decision to move in these directions increased our receptivity to the TIP and facilitated implementation. We are convinced that adopting the evidence-based recommendations of the TIP has enhanced our treatment of methamphetamine abuse, which also is now better attuned to the drug’s neurobiological effects. Nevertheless, the process was challenging, and structural factors combined with the nature of the TIP have limited our ability to implement the protocol systematically or to confirm its efficacy in our setting scientifically.



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WHAT WE ADOPTED: CONFIRMED PRACTICES

Prairie Ridge's client population is 93.4 percent Caucasian and 61.3 percent male; 47.7 percent of the population is referred by the criminal justice system, and 84.8 percent report an income of less than \$1,000 per month. Although Prairie Ridge had limited experience treating methamphetamine abuse before TIP 33, we had treated other stimulant abuse, mainly cocaine, for many years. We had already implemented, in one form or another, several of the protocols contained in the TIP. The TIP confirmed the validity of these existing practices and also encouraged us to focus additional attention on some of them. We found we could use the TIP without making wholesale changes to our organization and treatment methods, by simply reorganizing existing staff and services.

Relapse

It is rare for clients to go from active, full-blown stimulant addiction to complete abstinence. Rather, most clients go through a phase during which there are days without substance use and days with substance use (TIP 33, chapter 4).

Like many substance abuse programs, Prairie Ridge historically viewed relapse as a client's lack of commitment to abstinence, but in 1999 we began to recognize relapse as an episode in a chronic illness and started adjusting our policies accordingly. Instead of categorically denying clients reentry after a relapse, we might suggest they try a different treatment environment or prove their motivation. TIP 33, which suggests that "slips" should be regarded not as failures, but as oppor-

tunities to reevaluate the treatment plan, spurred us to go further in this direction. We now focus on the fact that clients come back after a relapse, and we have another opportunity to help them. This adjustment in attitude, which we extend to relapse-related behaviors such as missed appointments and resistance, especially during early treatment phases, has significantly increased our retention of clients.

Prairie Ridge staff were especially impressed with the sections of the TIP on relapse prevention, which promotes a focus on identifying the factors that led to the relapse and developing strategies for avoiding them in the future (such as cue avoidance; participation in new, positive activities; and development of coping and stress management skills). Counselors found the TIP's list of specific cues and triggers and corresponding avoidance strategies very helpful.

Of course, neither Prairie Ridge nor TIP 33 recommends that relapses continue indefinitely. Methamphetamine treatment entails working with clients as they struggle with cravings and, in many cases, relapse, but the only successful outcome is sustained abstinence.

Urinalysis Screens

Stimulant-dependent clients in outpatient programs need structure that provides support for engaging in healthy

behaviors. Urine testing is part of that structure. It should not be presented or used primarily as an investigative tool or to test the honesty of clients. Rather, it should be used and presented as a means of support for initiating and maintaining sobriety (TIP 33, chapter 4).

Prairie Ridge has always conducted urinalysis (UA) screens, but TIP 33 broadened our understanding of their importance. Following its advice, we have increased the frequency of screening and now aim to test clients twice a week during the early stages of engagement. Increased screening has not raised the rate of positive findings: More than 90 percent of results are negative.

The staff present the screens as a way for clients to document their abstinence, because many clients contend with people's mistrust and disbelief in their recovery progress. The UAs are a key indicator of success for clients who are answerable to the child welfare and corrections systems, or other authorities with which we routinely share results. We reduce screening frequency as clients progress through treatment, but we warn clients that they may be asked to submit a sample at any time.

WHAT WE ADOPTED: NEW PRACTICES

TIP 33 contains a wealth of information and suggestions related to methamphetamine's effects on the brain and their implications for treating clients. It encouraged us to confront difficult issues that we were aware of, but had not yet fully engaged, most particularly the extreme exhaustion clients feel immediately after entering treatment and the sexual side effects of methamphetamine abuse and withdrawal.

A Period of Rest

The initial period of stimulant abstinence is characterized by symptoms of depression, difficulty concentrating, poor memory, fatigue, craving, and paranoia. The duration of these symptoms varies; however . . . they typically last 10 to 15 days for methamphetamine users (TIP 33, chapter 4).

The TIP changed our thinking on new methamphetamine clients who participated weakly or asked to be excused from treatment sessions. It stresses that they may not be unmotivated, as the old-school philosophy assumed, but too exhausted and debilitated by the drug's neurobiological effects to keep up. Accordingly, we scrapped our practice of imposing strict treatment schedules on clients immediately after their arrival. Instead, we now direct our initial efforts toward clients'

TREATMENT IMPROVEMENT PROTOCOLS: EVIDENCE-BASED INNOVATION

The Substance Abuse and Mental Health Services Administration (SAMHSA) publishes TIPs to provide clinicians with best practice guidelines for the treatment of substance use disorders. Topics are selected in consultation with substance abuse experts in a wide variety of fields, and each TIP is composed by a non-government-affiliated consensus panel. TIPs are reviewed by a large group of experts before a final version is made available online and in print.

TIPs include a mixture of evidence-based recommendations and "front line" information that has not yet been empirically validated, but has shown signs of success in real-world treatment environments. In their executive summary of TIP 33, the authors state that "The Consensus Panel that developed this TIP tried to emphasize those treatment techniques and principles that have been established with empirical support. However, because the science of treating stimulant use disorders is barely a decade old, the Panel also reviewed and synthesized a set of techniques and principles developed and supported by leading addiction specialists, but with less empirical support." TIP 33, like all other TIPs, clearly distinguishes those treatment approaches that are empirically supported from those that are currently based on consensus opinion.

physical well-being, ensuring that they are well-fed and well-rested rather than expecting them to be awake first thing in the morning and attend group meetings. We have found that clients do not always need the full 10 to 15 days suggested by the TIP before engaging in treatment; in most cases, a few days of downtime monitored by our residential program nurse is sufficient. The implicit message this new approach sends our clients is not simply that they will benefit from a period of recuperation, but also that we understand their needs and state of mind.

We extend this policy to clients who are in jail. Instead of transferring them to our treatment center immediately, we send a counselor to the jail to assess the client's needs; if a short incarceration will not be detrimental to the client's health, we ask the county attorney to keep him or her for a week or two. Of course, it is unfortunate that we have to use the prison system in this way, but our counselors have noted that clients are mentally and physically readier to participate and face the demands of the treatment program if they are allowed this initial period of rest. We are convinced that they achieve better outcomes, too.

Sexual Issues

Stimulant-dependent clients can have tremendous concerns and anxieties about the compulsive sexual behaviors they

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TIP WORKSHEETS

TIP 33 features 44 worksheets dealing with a wide variety of topics, from identifying signs of stress and managing anger to listing positive recreational and exercise activities. Prairie Ridge counselors found these to be very useful tools for facilitating engagement, as they provided a framework for confronting issues that every client encounters and discussed easily accessible strategies for tackling common problems.

Worksheet #1, which asks clients to plan all of their activities for the day, from 7 a.m. to 11 p.m., may seem overly simplistic, but we found this type of hour-by-hour schedule to be very helpful in ensuring that clients avoid risky behaviors and situations. Similarly, worksheet #2, “Identifying External Cues and Triggers,” lays out a simple method of encouraging clients to recognize the people, places, events, and objects that are strongly associated with methamphetamine abuse. This worksheet, used in conjunction with worksheet #4, provides clients with an action plan for times when they are confronted with cues and triggers, allowing them to leave a counseling session with a set of easy-to-remember strategies that they can implement immediately.

engage in while using stimulants Client fears should be addressed, such as the fear that sex without drugs will be boring or impossible (TIP 33, chapter 4).

Unless sexual issues are addressed in treatment, they can pose barriers to engagement and retention

Our methamphetamine-abusing clients frequently report that the drug enhances sex and abstinence spoils it. TIP 33 persuaded us that failing to address sexual feelings and experiences in treatment can compromise some clients’ chances for recovery. Memories of the powerful sexual urges and sensations associated with the drug can be strong relapse triggers, as can a return to previous relationships or liaisons. The TIP called our attention, as well, to the link between methamphetamine and compulsive sexual activities that clients may look back upon with shame and confusion, such as promiscuous sex, behaviors known to increase the risk of AIDS, compulsive masturbation and pornography viewing, and homosexual behavior by heterosexual individuals. Unless such experiences and clients’ reactions to them are addressed in treatment, they can pose barriers to engagement and retention. Although there is always discomfort in talking with clients about sexual issues, the TIP provides counselors with science-based information that allows them to begin questioning clients and helping them work through their issues.

Methamphetamine and the Brain

Of all the changes TIP 33 prompted us to make, the most overarching and consequential was to adopt as a central basis for our activities the protocol’s extensive

information on how stimulants affect the nervous system and change feelings, emotions, and behavior. Chapter 2 describes the fundamentals of the nervous system, the role dopamine plays in the brain’s reward system, and the way that harmful behaviors, through positive reinforcement, can become repetitive. It also catalogues the deleterious psychological effects of methamphetamine abuse and withdrawal.

This information comprised the conceptual basis for our revised policies of giving clients rest, addressing sexual concerns, and rolling with resistance rather than confronting it. The information persuaded some counselors to cooperate with the new policies even though their previous experience and instincts argued that such “leniency” was inappropriate. Several staff commented as we began to implement the protocol that clients were not showing any real signs of progress, yet counselors were being asked to continue to devote valuable hours and resources to their treatment. These concerns faded as the counselors began to see improved engagement and results.

Counselors use the TIP’s information on methamphetamine’s neurobiological effects to ease clients’ common fears that they may have damaged their brains or contracted a mental illness while abusing methamphetamine. Many clients are relieved to learn that the emotions and sensations that they have been feeling—such as euphoria, paranoia, auditory hallucinations, and violent behaviors while using followed by drastic drops in mood and energy levels and severe depression after stopping—are direct biological consequences of the drug rather than symptoms of an underlying psychological condition.

Based on information in the TIP about the brain’s ability to repair itself over time, we tell our clients that current research gives grounds for hope that their symptoms will abate with abstinence, sleep, and good diet. We say this even though the research cited in the TIP suggests that chronic methamphetamine abuse has some long-term effects, such as decreased dopamine levels that can last as long as 4 years and psychotic symptoms that can sometimes persist through years of abstinence. We feel it is important, nevertheless, for clients to focus on the positive effects of abstinence rather than potential long-term problems they may or may not have to face.

Finally, we no longer encourage methamphetamine clients to consider using an antidepressant. The TIP’s authors stress that empirical data have not shown that

these medications increase either retention or abstinence. The key to managing psychological symptoms is time away from the drug.

ISSUES IN IMPLEMENTATION AND EVALUATION

Implementation of TIP 33 at Prairie Ridge was considerably facilitated by the 44 worksheets included in the protocol (see “TIP Worksheets”). Nevertheless, the process was not simple, and we have not been able to evaluate results objectively.

Implementation

As mentioned, some staff entered the transition to the protocol’s tolerant, client-centered approach with reluctance, although all ultimately recognized its validity. A more fundamental challenge for us was structural.

Prairie Ridge’s programs follow the recommendations of the American Society of Addiction Medicine (ASAM), which promote multiple levels of care, including residential programs, halfway houses, day programs, partial day programs, evening outpatient care, and continuing care. To offer counseling to groups at all these levels of care with the resources available to us, we must mix together clients who are addicted to a variety of drugs. We do not have enough counselors to form groups of only methamphetamine users, only cocaine users, and so on.

We therefore could not implement all the TIP 33 recommendations, as some are irrelevant for clients who abuse drugs other than stimulants. For the recommendations we did adopt, we needed either to assume they would be helpful for all clients, even though they were validated only for stimulant abusers, or to use them only in individual sessions with methamphetamine clients. Ultimately, we compromised. We present most of the information to methamphetamine-abusing clients during individual counseling sessions, but we also use some recommendations in group sessions, such as giving gift coupons to encourage attendance.

We have found the overall philosophy of the TIP to be applicable to all forms of drug abuse treatment. The protocol stresses that the initial period of engagement is critical to the overall success of treatment, and we found that many of the strategies for engaging clients could be applied to all of our clients. We have instituted the client-focused approach across the board, presenting multiple treatment options and allowing clients considerable say in which they receive. Some of the work-

sheets included in the TIP seem to work well with many types of clients.

Evaluation Hurdles

Several factors prevented Prairie Ridge from objectively evaluating the effectiveness of the protocols recommended in TIP 33. To measure the success of any new intervention, a program must implement it with fidelity. The fact that we did not make use of every recommendation in the protocol in the exact manner it was prescribed, as well as the fact that we were already using some elements before its publication, prevented us from effectively evaluating the protocol.

TIP 33 is not presented in the same manner as many other treatment manuals. The protocol is presented as

We found the overall TIP philosophy applicable to all forms of treatment

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a kind of cookbook, where some of the recommendations have been scientifically validated while others have not, and programs or individuals can decide for themselves how best to use the information. The manual does not lay out what a counselor should present during the first treatment session, the second session, the third, and so on; many details of implementation are left up to the individual treatment programs and counselors. It therefore is very difficult to determine the extent to which the TIP has been implemented and, consequently, its effect on the client population.

To determine if a manual such as TIP 33 is effective, executive directors and supervisors at treatment centers need to agree on a specific method of delivery and implement a monitoring system that holds counselors account-



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**Parental rights
terminations
have dropped**

able for following the agreed-upon rules. Because of our method of implementation, we do not have data on whether our outcomes have changed since implementing TIP 33. Although we cannot quantify improvements across all Prairie Ridge facilities, we have plenty of anecdotal evidence suggesting that the program has been effective. Moreover, one of Prairie Ridge's smaller treatment programs has been more closely monitoring certain outcomes, which so far have been quite positive.

Our facility in Algona, Iowa, received state Department of Human Services (DHS) funding for a program to reduce out-of-home placements of children and terminations of parental rights resulting from methamphetamine abuse. Phil Heath, director of the Algona treatment program, employed TIP 33 to achieve these goals. In the past 2 and a half years since implementation of the TIP, there have been only two parental rights terminations because of methamphetamine abuse by parents subsequent to treatment, which is a significant reduction compared with past years. UA-confirmed abstinence rates during 2004 and 2005 were between

70 and 80 percent. In addition, in 2004, 62 percent of children who had been placed out of the home were returned to their birth parents. Nearly 100 percent of clients reported to DHS that they were satisfied with the treatment services. The original DHS grant was intended for a period of only 6 months, but success rates were so impressive that it has now been extended three times over the course of 2 years. The program also has been nominated for an award at the annual Governor's Conference on Substance Abuse.

CONCLUSION

TIP 33 broadened and deepened our understanding of the neurobiological effects of methamphetamine and the way that they affect clients in treatment, and also gave us a roster of evidence-based and consensus-based procedures from which to choose. We adopted the TIP's overall client-centered philosophy and instituted new policies of giving clients a period of rest before beginning treatment, treating relapse as an event in recovery rather than a termination of it, addressing clients' sexual problems, and conducting more frequent UA screens. We extended some of the approaches suggested by the TIP to clients being treated for abuse of drugs other than stimulants.

Largely because of our client mix and resources, we were unable to collect data to measure the impact of the TIP on our clients' outcomes. Accordingly, we are left with the question: Should the fact that the TIP interventions have been proven effective in other settings add significance to our very strong clinical impression that they have helped our clients?

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